56-112. FREE-STANDING INTERMEDIATE CARE FACILITIES.

(a) Not later than January 1, 1982, and prior to the beginning of each fiscal year thereafter, the director shall determine the total prospective payment rate for all free-standing intermediate care facilities under medicaid contract with the director on or before the effective date of this chapter in the same manner as set forth in section 56-110, Idaho Code.

(b) For the first fiscal year of a free-standing intermediate care facility established on or after January 1, 1982, which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment for such facility in the same manner as specified in section 56-111, Idaho Code. Thereafter, such determination for such facility shall be done in accordance with subsection (a) of this section.

56-113. INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED.]

(a) Services provided by intermediate care facilities for the mentally retarded, with the exception of state operated facilities, shall be paid in accordance with the provisions of this section, and not as provided in any other section of this chapter, unless otherwise provided in this section. State operated facilities shall be reimbursed costs based on medicare reasonable cost provisions.

(b) Except as otherwise provided in this section, intermediate care facilities for the mentally retarded shall be reimbursed based on a prospective rate system without retrospective settlement effective October 1, 1996. In no event, shall payments to this class of facility exceed, in the aggregate, the amount which would be reimbursed using medicare cost reimbursement methods as defined in the medicare provider reimbursement manual (HCFA - pub. 15).

(c) The prospective rate shall consist of the following components

(1) A component for reasonable property costs which shall be computed using the property rental rate methodology set forth in section 56-108, Idaho Code, with the exceptions that the base rate shall exclude major moveable equipment and grandfathered rates will not apply. The initial base rate shall be eight dollars and ninety-four cents ($8.94) for facilities that accommodate residents in wheelchairs and five dollars and eighty-one cents ($5.81) for facilities that cannot accommodate residents in wheelchairs. The rates shall be adjusted annually as provided in section 56-108, Idaho Code; and

(2) A component for forecasted reasonable day treatment costs which shall be subject to a per patient day limit as provided in rule; and

(3) A component for all other allowable costs as determined in accordance with department rules which shall be subject to a limitation based on a percentage of the forecasted median for such costs of intermediate care facilities for the mentally retarded, excluding state operated facilities; and

(4) A component that provides an efficiency increment payment of twenty cents

($.20) for each one dollar ($1.00) per patient day that the facility is under the limit described in subsection (c)(3) of this section up to a maximum payment of three dollars ($3.00) per patient day.

(d) In the event that the prospective payment system authorized by this section does not receive required federal approval and the department and providers are unable to negotiate an acceptable reimbursement methodology, services provided by intermediate care facilities for the mentally retarded shall be reimbursed in the same manner as specified in section 56-110, Idaho Code, with property reimbursed as described in subsection (c)(1) of this section.

(e) The director may require retrospective settlement as provided by rule in limited circumstances including, but not limited to

(1) The facility fails to meet quality of care standards; or

(2) The facility is new or operated by a new provider, until such time as a prospective rate is set; or

(3) The prospective rate resulted from fraud, abuse or error.

(f) The director shall have authority to provide by rule, exceptions to the limitations described in subsection (c) of this section.

(g) The director shall promulgate the rules necessary to carry out the provisions of this section.

56-114. NEW FREE-STANDING SPECIAL CARE FACILITIES. For the first fiscal year of a free-standing special care facility established on or after January 1, 1989, which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment for such facility in the same manner as specified in section 56-111, Idaho Code. Thereafter, such determination for such facility shall be done in substantially the manner required in sections 56-110, 56-112 and 56-113, Idaho Code.

56-115. CAPITALIZATION OF ASSETS. For purposes of reporting costs to the department of health and welfare, each skilled care facility shall not capitalize minor movable equipment but shall expense it. Major movable equipment shall be capitalized. As used herein, equipment used directly or indirectly in providing health care for which medicaid reimbursement may be provided and which costs five hundred dollars ($500) or less shall be minor movable equipment and may be expensed as of the date of purchase. Major movable equipment which costs more than five hundred dollars ($500), must be capitalized and depreciated over the estimated useful life of the equipment under the rules of generally accepted accounting principles.

56-117. PAYMENT OF SPECIAL RATES. The director shall have authority to pay facilities at special rates for care given to patients who have long term care needs beyond the normal scope of

facility services. Patients with such needs may include, but are not limited to, ventilator assisted patients, certain pediatric patients, certain comatose patients, and certain patients requiring nasogastric or intravenous feeding devices. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The cost to a facility for services provided pursuant to the provisions of this section will be excluded from the computation of payments or rates under other provisions of this chapter.

56-118. REIMBURSEMENT FOR OXYGEN CONCENTRATORS. Oxygen concentrators used in lieu of supplying long-term care patients with bottled oxygen may, at the facility's option, be treated as an expense item in the year of acquisition and the cost thereof may be reported in the same expense category as oxygen.

56-120. EXISTING HOSPITAL-BASED FACILITIES.

(a) Not later than January 1, 1982, and prior to the beginning of each fiscal year thereafter, the director shall determine the maximum base payment rate for all hospital-based facilities that were under medicaid contract on or before such effective date as a class, using the following method:

(1) First, using worksheet B of the most recent cost report, or the most recent audited medicare cost report, if available, submitted to the director by each hospital-based facility, the director shall subtract such facility's total direct costs (excluding property and utility costs) from the sum of total general, ancillary and routine service costs (excluding property and utility costs) of both the facility and the hospital;

(2) Next, again using worksheet B of the same medicare cost report submitted by such facility, the director shall determine a percentage by dividing the sum of the total indirect costs of the hospital and the facility into the total indirect costs of the facility;

(3) Next, the director shall multiply the total direct general service costs (excluding property and utility costs), as used in paragraph (1) of this subsection, by the percentage derived from paragraph (2) of this subsection;

(4) Next, the director shall add to the total direct costs of the facility, as used in paragraph (1) of this subsection, the sum derived from paragraph (3) of this subsection and total costs attributable to central service, oxygen, and physical therapy services, taken from worksheet C of the facility's medicare cost report;

(5) Next, the director shall divide the sum derived from paragraph (4) of this subsection by the facility's total number of patient-days in the fiscal year covered by that facility's medicare cost report;

(6) Next, the director shall multiply the cost of care per patient-day obtained from paragraph (5) of this subsection by the percentage representing the annual combined inflator index

for the period in which the base rate is to be effective, as determined and agreed upon pursuant to section 56-130, Idaho Code;

(7) Next, the director shall combine the results from each hospital-based facility, as obtained from paragraph (6) of this subsection, to establish the range of costs of care per patient-day for all such facilities in the class; and

(8) Next, the director shall calculate the mean cost of care per patient-day for the class and the standard deviation from such mean, which shall be used to determine the base rate for the class, as specified in section 56-103(a), Idaho Code. The cost per patient-day resulting from paragraph (8) of this subsection shall constitute the basic payment for the cost of care per patient-day in each hospital-based facility in the class, and the director shall notify each such facility of such rate not later than sixty (60) days prior to the beginning date of the fiscal year in which it is to be effective. For purposes of this subsection, "medicare cost report" means form 2551, form 2552, or any similar successor form promulgated by the United States department of health and human services or its successor agency for the purpose of determining allowable, reimbursable costs for delivery of care or services under titles V, XVIII, or XIX of the social security amendments of 1965, as amended.

(b) In addition to the basic payment per patient-day of care, each hospital-based facility shall be paid on a prospective basis:

(1) Its actual property and utility costs per patient-day, to be determined by dividing its total projected property and utility costs, subject to the interest rate limitation, for its upcoming fiscal year, as submitted by each such facility to the director not later than ninety (90) days prior to the beginning date of such fiscal year, by the total number of patient-days estimated by such facility; and

(2) A monthly incentive payment equal to the computed difference between the facility's actual payment per patient-day and the base rate established for the class pursuant to section 56-103(a), Idaho Code, and this part. This computed difference shall be:

1. One-half (1/2) of the difference, where the one hundredth percentile applies to such facility's class;

2. One-third (1/3) of the difference, where the ninetieth percentile applies to such facility's class;

3. One-fourth (1/4) of the difference, where the eightieth percentile applies to such facility's class; or

4. One-sixth (1/6) of the difference, where the seventy-fifth percentile applies to such facility's class;

provided, that in no event shall the computed difference exceed one dollar and fifty cents ($1.50) per patient-day.

(c) Actual payments made by the director to each hospital-based facility pursuant to

sections 56-103 and 56-105, Idaho Code, and this section, shall be subject to audit and settlement under section 56-107, Idaho Code. In no event shall reimbursement to any facility exceed the usual and customary charges made to private pay patients.

56-121. NEW HOSPITAL-BASED FACILITIES. For the first fiscal year of a hospital-based facility established on or after April 1, 1985, which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment in the same manner as specified in section 56-120, Idaho Code, except that, in lieu of the medicare cost report, the hospital-based facility shall submit to the director, not later than ninety (90) days prior to the beginning date of the fiscal year in which the prospective rate is to be effective, a prospective budget containing the information necessary to complete the formula set forth in section 56-120, Idaho Code. The base rate for the facility shall be the base rate for the free-standing class. Thereafter, such determination for such facility shall be done in accordance with section 56-120, Idaho Code.

56-130. DEVELOPMENT OF PAYMENT, ADJUSTMENT, AUDIT AND SETTLEMENT MECHANISMS.

(a) Not later than seventy-five (75) days after the effective date of this section, the legislative council shall develop and transmit to the director recommendations for promulgation by rule, as specified in sections 56-104 through 56-107, Idaho Code, to include the following:

(1) A statistical model and appropriate indices for an annual combined inflator index, to include at least measures of cost increases in malpractice insurance, food, labor and other variable nonproperty cost categories;

(2) Uniform definitions, standards, and procedures for adjustments to prospective rates established by the director for facilities in the manner specified in this chapter, which take into account at least the following:

1. Unforeseen increases or decreases in cost categories greater or lesser than forecasted by the annual combined inflator index which are outside the control of any individual facility;

2. Unanticipated expenses required to prevent or correct conditions specified in section 39-4908(c), Idaho Code; and

3. Such other circumstances or emergencies which may be identified and agreed upon pursuant to subsection (b) of this section;

(3) Regulatory accounting, reporting, and auditing provisions which may be required; and

(4) Regulatory settlement provisions which may be required.

(b) The legislative council will develop the items specified in subsection (a) of this

section;

(1) In cooperation with an advisory committee, appointed by the legislative council, to be composed of representatives of the director, the Idaho society of certified public accountants, and free-standing skilled care, free-standing intermediate care, and hospital-based facilities; and

(2) In a manner which will achieve the principles of prospective reimbursement as stated in parts A, B, and C of this chapter.

56-131. MULTIPLE-USE PLANS. The director shall promulgate such rules, as he deems advisable to enable and encourage facilities to adopt plans for offering additional services or programs within their institutions which will promote appropriate levels of care for recipients residing in their service areas and, as a result, achieve cost savings for the medicaid program. In developing such rules, the director shall consult with representatives of free-standing skilled care, free-standing intermediate care, free standing special care, and hospital-based facilities.

56-132. DISPUTES.

(a) If any facility wishes to contest the way in which a rule or contract provision relating to the prospective, cost-related reimbursement system was applied to such facility by the director, it shall first pursue the administrative review process set forth in section 56-133, Idaho Code.

(b) The administrative review process in section 56-133, Idaho Code, need not be exhausted if a facility wishes to challenge the legal validity of a statute, rule, or contract provision.

56-133. ADMINISTRATIVE REVIEW PROCESS.

(a) Within thirty (30) days after a facility is notified of an action or determination it wishes to challenge, such facility shall request in writing that the director review such determination. The request shall be signed by the licensed administrator of the facility, shall identify the challenged determination and the date thereof, and shall state as specifically as practicable the grounds for its contention that the determination was erroneous. Copies of any documentation on which such facility intends to rely to support its position shall be included with the request.

(b) After receiving a request meeting the above criteria, the director will contact the facility to schedule a conference for the earliest mutually convenient time. The conference shall be scheduled for no later than thirty (30) days after a properly-completed request is received, unless both parties agree in writing to a specified later date.

(c) The facility and the director shall attend the conference. In addition, representatives selected by the facility may attend and participate. The facility shall bring to the conference, or provide to the director in advance of the conference, any documentation on which the facility

intends to rely to support its contentions. The parties shall clarify and attempt to resolve the issues at the conference. If additional documentation is needed to resolve the issues, a second session of the conference shall be scheduled for not later than thirty (30) days after the initial session, unless both parties agree in writing to a specific later date.

(d) A written decision by the director will be furnished to the facility within thirty (30) days after the conclusion of the conference.

(e) If the facility desires review of an adverse decision of the director, it shall, within twenty-eight (28) days following receipt of such decision, request a hearing in writing on the contested matter, in accordance with the provisions of chapter 52, title 67, Idaho Code.

56-134. DENIAL, SUSPENSION, REVOCATION OF LICENSE OR PROVISIONAL LICENSE -- PENALTY. The director is authorized to deny, suspend, or revoke a license or provisional license or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars ($1,000) per violation in any case in which it finds that the facility, or any partner, officer, director, owner of five per cent (5%) or more of the assets of the facility, or managing employee:

(1) Failed or refused to comply with the requirements of this chapter, or the rules and regulations established hereunder; or

(2) Has knowingly or with reason to know made a false statement of a material fact in any record required by this chapter; or

(3) Refused to allow representatives or agents of the director to inspect all books, records, and files required to be maintained by the provisions of this chapter, or to inspect any portion of the facility's premises; or

(4) Wilfully prevented, interferred [interfered] with, or attempted to impede in any way the work of any duly authorized representative of the director and the lawful enforcement of any provision of this chapter; or

(5) Wilfully prevented or interferred [interfered] with any representative of the director in the preservation of evidence of any violation of any of the provisions of this chapter, or the rules and regulations promulgated hereunder.

56-135. ADOPTION OF RULES. The director shall adopt, promulgate, amend,and rescind such administrative rules as are necessary to carry out the policies and purposes of this chapter, as provided in chapter 52, title 67, Idaho Code.

56-136. PHYSICIAN REIMBURSEMENT.

(1) Beginning with fiscal year 1996, the rate of reimbursement for all medicaid-covered physician services rendered to medicaid recipients shall be adjusted each fiscal year. Each fiscal

year adjustment shall be determined by the director and shall equal the year over year inflation rate forecasted as of the midpoint of the fiscal year by the all item, goods and services index in the pacific northwest as published by data resources incorporated. Such forecast index shall be the last published forecast prior to the start of the fiscal year. Provided however, an adjustment may exceed the index rate cited in this section at the discretion of the legislature.

(2) Actual payments made by the director to each physician shall not exceed the usual and customary charges made to private pay patients.

(3) For the purposes of this section, "physican" means a person licensed to practice medicine pursuant to chapter 18, title 54, Idaho Code.

(4) The amount to be paid under the provisions of this section shall in no event exceed any limitations imposed by federal law or regulation.

Appendix B
Facility Definitions From Idaho Code:
Bold Items Are Applicable to Idaho State Plan Attachment 4.19-D

Provisions in this appendix are only applicable to the Idaho State Plan to the extent that such provisions are directly related to references in the plan to these provisions. In the event of any conflict, difference of definition, ambiguity, discrepancy, or dispute, arising from provisions in this appendix, the provisions of this appendix are subordinate to state plan provisions not in this appendix as determined by the Department. Furthermore, any references to laws, rules, or documents which are exclusive to this appendix (which are not in Attachment 4.19-D of the State Plan) are to be deemed extraneous to the plan.

TITLE 39
HEALTH AND SAFETY
CHAPTER 13
HOSPITAL LICENSES AND INSPECTION

39-1301. DEFINITIONS. For purposes of this chapter the following definitions will apply:

(a) "Hospital" means a facility which:

(1) Is primarily engaged in providing, by or under the supervision of physicians,

(a) concentrated medical and nursing care on a twenty-four (24)hour basis to inpatients experiencing acute illness; and

(b) diagnostic and therapeutic services for medical diagnosis and treatment, psychiatric diagnosis and treatment, and care of injured, disabled, or sick persons; and

(c) rehabilitation services for injured, disabled, or sick persons; and

(d) obstetrical care.

(2) Provides for care of two (2) or more individuals for twenty-four(24) or more consecutive hours.

(3) Is staffed to provide professional nursing care on a twenty-four (24) hour basis.

(b) "Skilled nursing facility" (nursing home) means a facility whose design and function shall provide area, space and equipment to meet the health needs of two (2) or more individuals who, at a minimum, require inpatient care and services for twenty-four (24) or more consecutive hours for unstable chronic health problems requiring daily professional nursing supervision and licensed nursing care on a twenty-four (24) hour basis, restorative, rehabilitative care, and

assistance in meeting daily living needs. Medical supervision is necessary on a regular, but not daily, basis.

(c) "Intermediate care facility" (nursing home) means a facility:

(1) Whose design and function shall provide area, space and equipment to meet the restorative, rehabilitative, recreational, intermittent health needs, and daily living needs of two (2) or more individuals who require in-residence care and services for twenty-four (24) or more consecutive hours;

(2) Whose design and function will provide for regular but less than daily medical and skilled nursing care.

(d) "Intermediate care facility for the mentally retarded (ICFMR)" means a nonnursing home facility, designed and operated to meet the unique educational, training, habilitative and medical needs of the developmentally disabled through the provision of active treatment.

(e) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(f) "Government unit" means the state, or any county, municipality, or other political subdivision, or any department, division, board or other agency thereof.

(g) "Licensing agency" means the department of health and welfare.

(h) "Board" means the board of health and welfare.

(i) "Physician" means an individual licensed to practice medicine and surgery by the Idaho state board of medicine or the Idaho state board of podiatry.